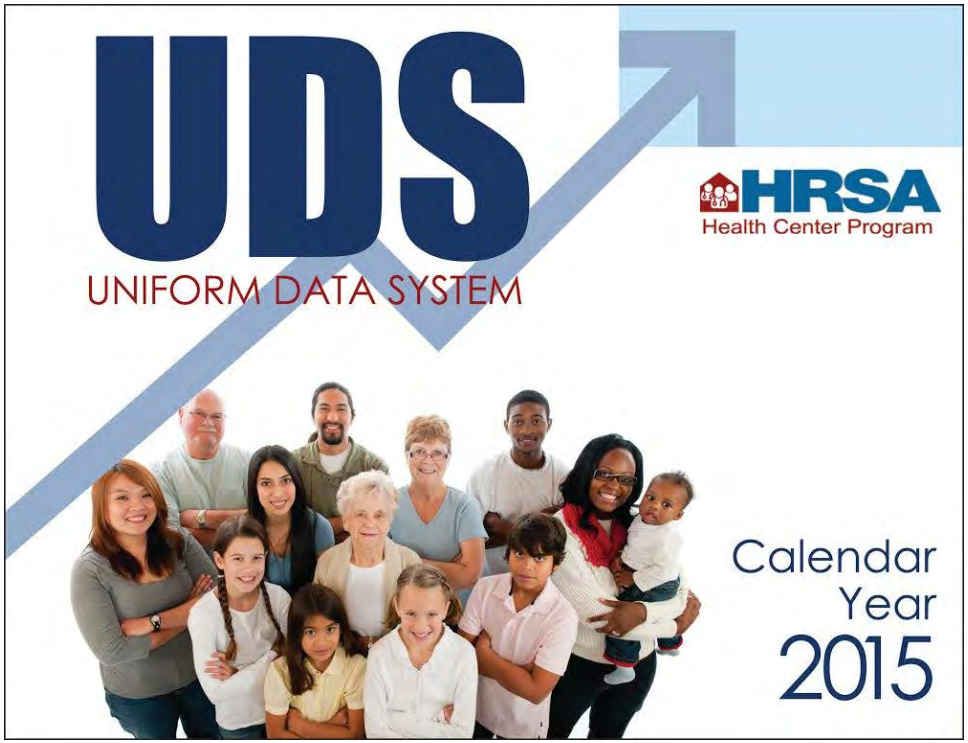


PREPARING FOR AND UNDERSTANDING YOUR UDS SUBMISSION

Bureau of Primary Health Care

Date: November 16, 2015 from 1:00-2:30 (ET)

Agenda

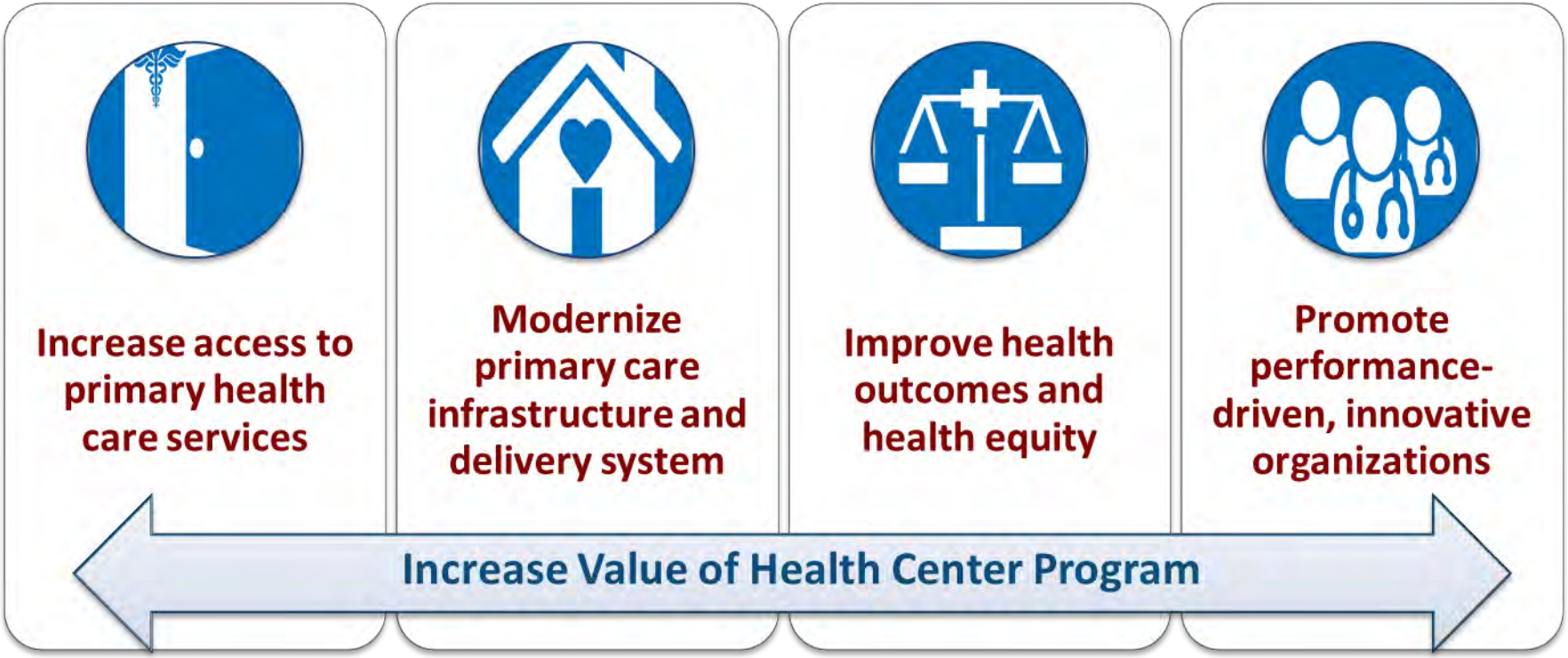
- Objectives
- Importance of the UDS and Key Definitions
- How to Use UDS Data
- Report Preparation Considerations
- Review Data for Accuracy
- Other Considerations
- Questions

Objectives

- Understand the importance of the UDS and critical dates in the process
- Implement processes and systems for accurate submission of the UDS report
- Understand table-specific considerations

Primary Care Mission and Strategies

Improving the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.



UDS

UNIFORM DATA SYSTEM

HRSA Health Center Program

Importance of UDS and Key Definitions

What is the Uniform Data System (UDS)?

- Standardized set of data reported by federally supported Health Center programs:
  - Section 330 grantees – Community Health Center (CHC), Health Care for the Homeless (HCH), Migrant Health Center (MHC), and Public Housing Primary Care Program (PHPC)
  - Health Center Program look-alikes
  - Bureau of Health Workforce (BHW) primary care clinics
- Reported for the approved scope of project for the period January 1 - December 31, 2015

12 Tables Provide a Snapshot of Patients and Performance

What is Reported	Table(s)
Patients served and their socio-demographic characteristics	ZIP Code, 3A, 3B, 4
Types and quantities of services provided	5, 6A
Staffing mix and tenure	5, 5A
The care delivered/quality of care provided	6A, 6B, 7
Costs of providing services	8A
Revenue sources	9D, 9E
Additional Reporting Requirement	**Form**
Electronic health record (EHR) capabilities and quality recognition	EHR Form

Why is the UDS important?

- UDS data are used to:
  - Ensure compliance with legislative and regulatory requirements
  - Improve health center performance and operations
  - Report overall program accomplishments
  - Identify trends over time
  - Enable HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations
  - Compare with national data to review differences between the U.S. population at large
  - Inform Health Center programs, partners, and communities about the patients served by health centers

Health Center Impact

Source: CY 2014 Uniform Data System Rollup Reports

CY 2014	Grantees	Look-alikes	BHW
Number of health centers	1,278	81	50
Patients served	22,873,243	881,524	84,670
Agricultural workers or dependents	891,796	12,854	41
Homeless	1,151,046	13,575	4,631
Public housing	429,251	2,825	1,499
School-based	569,107	9,140	4,762
Veterans	289,391	5,879	439
Visits	90,379,441	3,179,753	267,358
Employed staff/volunteers	710,331	5,569	616
At or below 200% poverty	92%	93%	89%
Uninsured	28%	25%	44%
Racial and/or ethnic minority	62%	74%	56%

- 23.8 million total patients served by 1,409 health centers
- The 93.8 million total visits capture comprehensive services provided, including: medical, dental, mental health, substance abuse, vision, other professional, and enabling services
- 716,000 FTEs—though the number of people employed is far greater

Key Definitions used in UDS

“Patient” Defined: Who counts?

- Patient = “Head Count”—total number of individuals who receive at least one “countable” visit during the reporting year
  - Patients are counted once and only once, regardless of the number or scope of visits
  - Not all “contacts” are counted as a visit
  - Must have at least one visit that is reported on Table 5 to count as a patient

"Visit" Defined: What counts?

- Currently, visits are defined as face to face, one to one, between a patient and provider
  - Exception: Behavioral health
- Must be documented in a patient chart
- Include visits by paid, volunteer, and contracted providers
- Count paid referral, nursing home, hospital, home visits
- Only one visit/patient/provider type/day
  - Unless two different providers at two different sites
- Only one visit/provider/patient/day regardless of number of services provided

"Visit" Defined: What doesn't count?

- Do not count immunization only, lab only, dental varnishing or fluoride treatments, mass screenings, health fairs, outreach, or pharmacy visits
- No group health education, group diabetes sessions, etc.
- Not all staff report visits
  - No services are counted for staff providing ancillary services, outreach and eligibility assistance, non-health-related services, and non-clinical support

"Full-Time Equivalent (FTE)" Defined

- Who is counted? All personnel who contribute to the operations of the health center at approved locations and within the scope of the project
  - Employees, contracted staff, residents, locums, and volunteers
  - Do not count paid referral provider FTEs
- How is FTE calculated?
  - 1.0 FTE is equivalent to one person working full-time for one year; prorate part-time and part-year staff
    - Cannot use staff list as of December 31
  - Report FTE based on work performed
    - FTEs can be allocated across multiple categories
  - While most sites use 2,080 hours as full-time, some staff actually work 36- or 35-hour weeks; if that is the case, then 1,872 paid hours (36 X 52) might be one FTE

"Tenure" Defined

- Who is counted?
  - Providers and key management
  - Staff who contribute to the operations of the health center at approved locations and within the scope of the project
- Specifically:
  - Full- and part-time staff
    - Employees (full- and part-time or -year), onsite contracted staff, and NHSC assignees
  - Other service providers
    - Residents, locum tenans, on-call providers, volunteers, and off-site contract providers
  - Include persons working on last day of the year and those who have the day off, but are scheduled to return
  - Do not count paid referral providers or individuals who may work many hours but do not have a regular schedule
  - For health centers that have added a site, or are newly funded or designated, track tenure back to when the site or entity began serving patients

How is tenure calculated?

- Count the number of persons in their current position as of December 31
  - This is a head count, not FTE calculation
- Count the number of consecutive months for each person
  - Months reported would be greater than 12 if the person held the position for more than one year

“Prenatal Patient” Defined

- Women who are either provided direct care or referred for care
- Includes patients who:
  - Received all their prenatal care from the health center
  - Were referred by the health center for all their prenatal care
  - Began prenatal care with another provider but transferred to the health center
  - Began prenatal care with the health center, but then transferred to another provider
  - Were provided with all prenatal care by a health center, but delivered by another provider

"Universe" Defined

- Universe: All patients who meet the reporting criteria
  - Tables 6B and 7, Column A

Section C - Childhood Immunization

Line	Childhood Immunization	Total Number of patients with 3rd birthday during measurement year (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to December 31)	Universe		

"Sample or EHR" Defined

- All those in EHR or sample of 70 patients
  - May use an EHR in lieu of a chart sample if at least 80 percent of all health center patient records are included in the EHR for any given measure
  - BPHC prefers reporting from an EHR
    - Note: Most health centers have an EHR in place
  - Tables 6B and 7, Column B

Section C - Childhood Immunization

Line	Childhood Immunization	Total Number of patients with 3rd birthday during measurement year (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to December 31)		Sample or Universe	

"Measurement Standard" Defined

- Measurement Standard: Number of charts whose clinical record indicates that the measurement rules and criteria have been met
  - Tables 6B and 7, Column A

Section C - Childhood Immunization

Line	Childhood Immunization	Total Number of patients with 3rd birthday during measurement year (a)	Number Charts Sampled or EHR total (b)	Number of Patients Immunized (c)
10	MEASURE: Children who have received age appropriate vaccines prior to their 3rd birthday during measurement year (on or prior to December 31)			Records meeting the measurement standard

UDS

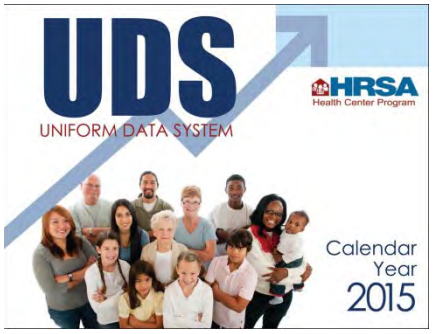
UNIFORM DATA SYSTEM

HRSA Health Center Program

How to Use UDS Data

Patient Profile Tables

ZIP Code Table, Tables 3A, 3B, and 4



- Patients by ZIP Code (by primary medical insurance)

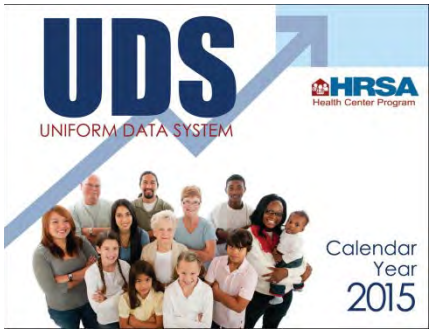
ZIP Code (a)	None/Uninsured (b)	Medicaid / CHIP/Other Public (c)	Medicare (d)	Private (e)	**Total Patients (f)**
Other ZIP Codes					
Unknown Residence					
Total					

- Table 3A: Patients by Age and Gender
  - Table 3A Grant Report: completed for each additional 330 funding stream

	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		

Patient Profile Tables

ZIP Code Table, Tables 3A, 3B, and 4



- Table 3B: Patients by Race and Ethnicity and Linguistic Barriers

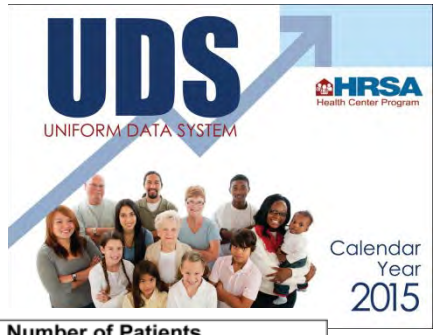
PATIENTS BY RACE		PATIENTS BY HISPANIC OR LATINO ETHNICITY			
		HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED/ REFUSED TO REPORT ETHNICITY (c)	TOTAL (d) (Sum Columns a+b+c)
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	**T**otal **H**awaiian/**O**ther **P**acific **I**slander (SUM LINES 2A + 2B)				
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported/Refused to report race				
8.	**TOTAL PATIENTS** (SUM LINES 1+2 + 3 TO 7)				

PATIENTS BY LANGUAGE		NUMBER (a)
12.	**PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH**	

  - Table 3B Grant Report: Completed for each additional funding stream

Patient Profile Tables

ZIP Code Table, Tables 3A, 3B, and 4



- Table 4: Patients by Income, Insurance, and Target Populations

  – Table 4 Grant Report: Completed for each additional funding stream

Line	Characteristic	Number of Patients
Line	**Income as Percent of Poverty Level**	**Number of Patients (a)**
1.	100% and below	
2.	101–150%	
3.	151–200%	
4	Over 200%	
5.	Unknown	
6.	**TOTAL** (Sum Lines 1–5)	

Line	Principal Third Party Medical Insurance	0-17 years old (a)	18 and older (b)
7.	**None/Uninsured**		
8a.	Regular Medicaid (Title XIX)		
8b.	CHIP Medicaid		
8.	**Total Medicaid (Line 8a + 8b)**		
9a.	Dually Eligible (Medicare and Medicaid)		
9.	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a.	Other Public Insurance Non-CHIP (specify:)		
10b.	Other Public Insurance CHIP		
10.	**Total Public Insurance (Line 10a + 10b)**		
11.	**Private Insurance**		
12.	**TOTAL** (Sum Lines 7 + 8 + 9 +10 +11)		

Line	Managed Care Utilization Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	**Total Member months (Sum Lines 13a + 13b)**					

Line	Special Populations	Number of Patients
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	**Total Agricultural Workers or Dependents** (All Health Centers Report This Line)	
17.	Homeless Shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling Up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	**Total Homeless** (All Health Centers Report This Line)	
24.	**Total School Based Health Center Patients** (All Health Centers Report This Line)	
25.	**Total Veterans** (All Health Centers report this line)	
26.	**Total Public Housing Patients** (All Health Centers Report This Line)	

Patient Profile Data

ZIP Code Table, Tables 3A, 3B, and 4

- How to use patient profile data:
  - Describes the patients you serve and demonstrates if you served target populations proposed in your application
  - Permits mapping of your service area and is available in UDS Mapper to consider how your service area aligns with your proposed service area (Form 5B vs. ZIP Code Table)
  - Quantifies the special populations and individuals served with financial, cultural, racial/ethnic, and linguistic barriers to care
  - Calculates performance measures utilized by BPHC (such as cost per patient)

Staffing, Tenure, and Utilization Profile

Tables 5 and 5A

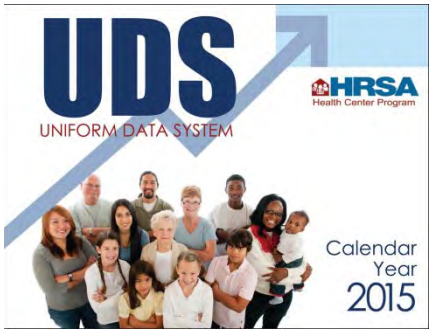
- Table 5: Types and Quantities of Services Provided and Staff Who Provide these Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	**Total Physicians** (Lines 1–7)			
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)			
11	Nurses			
12	Other Medical Personnel			
13	Laboratory Personnel			
14	X-ray Personnel			
15	**Total Medical** (Lines 8 + 10a through 14)			
16	Dentists			
17	Dental Hygienists			
18	Other Dental Personnel			
19	**Total Dental Services** (Lines 16–18)			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	**Total Mental Health** (Lines 20a–c)			
21	**Substance Abuse Services**			
22	**Other Professional Services (specify___)**			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			

- Report FTEs, visits, and patients
- Table 5 Grant Report: Completed for each additional funding stream and limited to Columns B and C (only)

Staffing, Tenure, and Utilization Profile

Tables 5 and 5A



- Table 5A: Tenure for Health Center Staff
  - Head count of persons as of December 31
  - Months of service for selected staff categories and positions
  - From personnel records
- Please do not report FTE as tenure—NOT the same thing

		Full and Part Time		Locum, On-Call, etc.	
Line	Health Center Staff	Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1	Family Physicians				
2	General Practitioners				
3	Internists				
4	Obstetrician/Gynecologists				
5	Pediatricians				
7	Other Specialty Physicians				
9a	Nurse Practitioners				
9b	Physician Assistants				
10	Certified Nurse Midwives				
11	Nurses				
16	Dentists				
17	Dental Hygienists				
20a	Psychiatrists				
20a1	Licensed Clinical Psychologists				
20a2	Licensed Clinical Social Workers				
20b	Other Licensed Mental Health Providers				
22a	Ophthalmologist				
22b	Optometrist				
30a1	Chief Executive Officer				
30a2	Chief Medical Officer				
30a3	Chief Financial Officer				
30a4	Chief Information Officer				

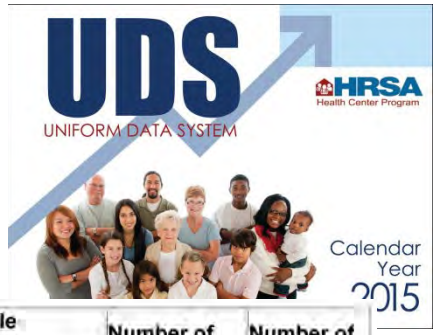
Staffing, Tenure, and Utilization Data

Tables 5 and 5A

- How to use staffing and utilization data:
  - Describes what staffing resources you have to provide services to your patients
  - Demonstrates retention of staff
  - Describes comprehensive services provided to patients to demonstrate quantity of services (e.g., medical, dental, enabling) offered and number of patients receiving the services

Clinical Profile Tables

Tables 6A, 6B, and 7



- Table 6A: Selected Diagnoses and Services Rendered
  - Table 6A Grant Report: Completed for each additional funding stream

Service Category		Applicable ICD-9-CM or CPT-4/II Code	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (A)	Number of Patients (B)
Selected Diagnostic Tests/Screening/Preventive Services					
21.	HIV test	**CPT-4:** 86689; 86701-86703; 87390-87391	**CPT-4:** 86689; 86701-86703; 87390-87391		
21a.	Hepatitis B test	**CPT-4:** 86704, 86706, 87515-17	**CPT-4:** 86704, 86706, 87515-17		
21b.	Hepatitis C test	**CPT-4:** 86803-04, 87520-22	**CPT-4:** 86803-04, 87520-22		
22.	Mammogram	**CPT-4:** 77052, 77057 OR **ICD-9:** V76.11; V76.12	**CPT-4:** 77052, 77057 OR **ICD-10:** Z12.31		
23.	Pap test	**CPT-4:** 88141-88155; 88164-88167, 88174-88175 OR **ICD-9:** V72.3; V72.31, V72.32; V76.2	**CPT-4:** 88141-88155; 88164-88167, 88174-88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4:** 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748	**CPT-4:** 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748		
24a.	Seasonal Flu vaccine	**CPT-4:** 90654 – 90662, 90672-90673, 90685-90688	**CPT-4:** 90654 – 90662, 90672-90673, 90685-90688		
25.	Contraceptive management	**ICD-9:** V25.xx	**ICD-10:** Z30-		

Clinical Profile Tables

Tables 6A, 6B, and 7

- Table 6B: Quality of Care Measures
  - "Process measures": If patients receive timely routine and preventive care, then we can expect improved health

- Trimester of Entry into Prenatal Care
- Childhood Immunization
- Cervical Cancer Screening
- Weight Assessment and Counseling for Children and Adolescents
- Adult Weight Screening and Follow-Up
- Tobacco Use Screening and Cessation Intervention
- Asthma Pharmacologic Therapy
- Coronary Artery Disease (CAD): Lipid Therapy
- Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy
- Colorectal Cancer Screening
- HIV Linkage to Care
- Patients Screened for Depression and Follow-Up
- Dental Sealants

Clinical Profile Tables

Tables 6A, 6B, and 7

- Table 7: Health Outcomes and Disparities
  - "Process measures": If these measurable outcomes are improved, then negative health outcomes will be less likely
  - Reported by race and ethnicity

- Low Birth Weight
- Controlled Hypertension
- Poorly Controlled Diabetes

Line #	Race and Ethnicity
	Hispanic/Latino
1a	Asian
1b1	Native Hawaiian
1b2	Other Pacific Islander
1c	Black/African American
1d	American Indian/Alaska Native
1e	White
1f	More than One Race
1g	Unreported/Refused to Report Race
	Subtotal Hispanic/Latino
	Non-Hispanic/Latino
2a	Asian
2b1	Native Hawaiian
2b2	Other Pacific Islander
2c	Black/African American
2d	American Indian/Alaska Native
2e	White
2f	More than One Race
2g	Unreported/Refused to Report Race
	Subtotal Non-Hispanic/Latino
	Unreported/Refused to Report Ethnicity
h	Unreported/Refused to Report Race and Ethnicity
i	*Total*

Clinical Profile Data

Tables 6A, 6B, and 7

- How to use clinical profile data:
  - Demonstrates achievements in national benchmarks for routine and preventive care, chronic care, prenatal care, and healthy behaviors
  - Quantifies the comprehensiveness and continuity of services provided
  - Identifies opportunities for monitoring and improving quality improvement activities
  - For ongoing quality improvement at the health center

Electronic Health Record (EHR) Capabilities Form

- Series of questions on health information technology (HIT) capabilities, including EHR interoperability and leverage for Meaningful Use
- Includes the implementation of EHR, certification of systems, how widely adopted the system is throughout the health center and its providers, and national and/or state quality recognition (accreditation or PCMH)
- Use of EHR Form
  - Demonstrates EHR capabilities and quality recognition achievements

Financial Profile Tables

Tables 8A, 9D, and 9E

- Table 8A: Financial Costs
  - Column A = Total accrued costs (by cost center)
  - Column B = Allocation of total facility and non-clinical support (Line 16, Column A) to each cost center

		Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Financial Costs for Medical Care				
1.	Medical Staff			
2.	Lab and X-ray			
3.	Medical/Other Direct			
4.	**TOTAL MEDICAL CARE SERVICES** (Sum Lines 1 Through 3)			
Financial Costs for Other Clinical Services				
5.	Dental			
6.	Mental Health			
7.	Substance Abuse			
8a.	Pharmacy not including pharmaceuticals			
8b.	Pharmaceuticals			
9.	Other Professional (Specify _____)			
9a.	Vision			
10.	**TOTAL OTHER CLINICAL SERVICES** (Sum Lines 5 through 9a)			
Financial Costs of Enabling and Other Program Related Services				
11a.	Case Management			
11b.	Transportation			
11c.	Outreach			
11d.	Patient and Community Education			
11e.	Eligibility Assistance			
11f.	Interpretation Services			
11g.	Other Enabling Services (specify: _____)			
11.	Total Enabling Services Cost (Sum Lines 11a through 11g)			
12.	Other Related Services (specify:_____)			
13.	**TOTAL ENABLING AND OTHER SERVICES** (Sum Lines 11 and 12)			
Facility and Non-Clinical Support Services and Totals				
14.	Facility			
15.	Non Clinical Support Services			
16.	**TOTAL Facility and Non Clinical Support Services** (Sum lines 14 and 15)			
17.	**TOTAL ACCRUED COSTS** (Sum Lines 4 + 10 + 13 + 16)			
18.	Value of Donated Facilities, Services, and Supplies (specify: _____)			
19.	**TOTAL WITH DONATIONS** (Sum Lines 17 and 18)			

Financial Profile Tables

Tables 8A, 9D, and 9E

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wrap Around Current Year (c1)**	**Collection of Reconciliation/ Wrap Around Previous Years (c2)**	**Collection of Other Retro Payments: P4P, Risk Pools, Withholds etc. (c3)**	**Penalty/ Payback (c4)**	**Allowances (d)**	**Sliding Discounts (e)**	**Bad Debt Write Off (f)**

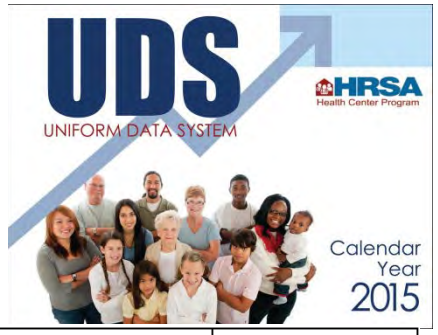
Line	Payer Category
1.	Medicaid Non-Managed Care
2a.	Medicaid Managed Care (capitated)
2b.	Medicaid Managed Care (fee-for-service)
3.	**Total Medicaid** (Lines 1+ 2a + 2b)
4.	Medicare Non-Managed Care
5a.	Medicare Managed Care (capitated)
5b.	Medicare Managed Care (fee-for-service)
6.	**Total Medicare** (Lines 4 + 5a+ 5b)

7.	Other Public including Non-Medicaid CHIP (Non Managed Care)
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)
9.	**TOTAL OTHER PUBLIC** (LINES 7+ 8A +8B)
10.	Private Non-Managed Care
11a.	Private Managed Care (capitated)
11b.	Private Managed Care (fee-for-service)
12.	**TOTAL PRIVATE** (LINES 10 + 11A + 11B)
13.	Self Pay
14.	**TOTAL** (LINES 3 + 6 + 9 + 12 + 13)

- Table 9D: Patient-Related Revenue
  - Charges during 2015 by payer type
  - Cash income received during the year
  - Charges and income are by payer: Medicaid, Medicare, Other Public, Private, Self-Pay

Financial Profile Tables

Tables 8A, 9D, and 9E



- Table 9E: Other Revenues
  - Report:
    - Income received in 2015 (on a cash basis) from grants, contracts, and other non-patient service-related sources
    - Based and reported on the line of the last party to have the money before health center received funds
  - Do not report:
    - Money reported on Table 9D
    - Donations reported on Table 8A (e.g., in-kind facilities, services, or supplies)
    - Do not report capital received as loan

SOURCE		AMOUNT (a)
BPHC GRANTS (ENTER AMOUNT DRAWN DOWN – CONSISTENT WITH PMS-272)		
1a.	Migrant Health Center	
1b.	Community Health Center	
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	TOTAL HEALTH CENTER (SUM LINES 1A THROUGH 1E)	
1j.	Capital Improvement Program Grants (excluding ARRA)	
1k.	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	
1.	TOTAL BPHC GRANTS (SUM LINES 1G + 1J + 1K)	
OTHER FEDERAL GRANTS		
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants (specify:_____)	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
5.	TOTAL OTHER FEDERAL GRANTS (SUM LINES 2 – 4A)	
NON-FEDERAL GRANTS OR CONTRACTS		
6.	State Government Grants and Contracts (specify:_____)	
6a.	State/Local Indigent Care Programs (specify:_____)	
7.	Local Government Grants and Contracts (specify:_____)	
8.	Foundation/Private Grants and Contracts (specify: _____)	
9.	TOTAL NON-FEDERAL GRANTS AND CONTRACTS (SUM LINES 6 +6A + 7+8)	
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (specify:_____)	
11.	TOTAL REVENUE (LINES 1+5+9+10)	

Financial Profile Data

Tables 8A, 9D, and 9E

- How to use financial profile data:
  - Describes how expenses relate to revenues to evaluate profitability
  - Describes diversification of funding sources
  - Calculates performance measures utilized by BPHC (such as medical costs per medical visit and per patient, payer, and grant mix)

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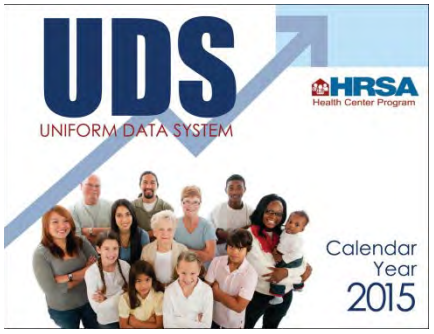
Report Preparation Considerations

Patient Profile Considerations



- Ensure data is collected and entered into your EHR or Practice Management Systems during initial patient registration and updated regularly. Query patients about:
  - Residence address (for ZIP code)*
  - Date of birth
  - Gender
  - Race and ethnicity
  - Language
  - Income (based on federal poverty guidelines) *
  - Primary medical insurance*
  - Demographic status (agricultural worker, homeless, veteran) *

Train your front desk staff on collecting and entering this information, and updating it regularly

* To be updated regularly

Staffing and Utilization Profile Considerations

- Ensure tenure calculations follow UDS definitions
  - Staffing data is typically pulled from payroll and/or Human Resources systems for tenure
- Calculate FTEs based on hours paid and the health center's base for that position
- Refer to Appendix A personnel list for staff titles that align with Table 5 lines
- Ensure data entered for Table 5 Table 8A costs

Staff entering Table 5 FTE needs to coordinate with staff entering Table 8A costs to ensure alignment

Clinical Profile Considerations

- Understand data sources—typically billing, practice management, and EHRs are used to generate data for these tables
- Ensure patient demographics in clinical system (EHR) align with patient registration data
- Develop methods to collect outcome data from outside providers (e.g., prenatal care, deliveries, immunization records)
- Ensure data fields required for performance measurements are included in EHR

Train your clinical staff on using systems to report data and work with vendors to ensure results/ outputs are aligned to definitions

Financial Profile Considerations

- Ensure payer revenue aligns with data reported by insurance and managed care enrollment
- Report charges that correspond with billable visit data
- Maintain process for reclassification of charges to appropriate payers

Financial staff must ensure systems are in place to properly record accrued costs, charges, and cash collections by payer, including reclassifications

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Review Data for Accuracy Prior to Submission

Review Data for Accuracy

- Develop checklist to verify data elements on each table
- Run the audit report, review edits, and correct or respond with clear explanations about data validity
  - Work as a team to understand and address issues
  - Verify data coming out of systems and correct query logic when there are errors
  - Explain large inter-year changes in data
- Review the issues raised by your reviewer and work with your team to resolve data issues

ZIP Code Table Data Checks

- ZIP code data should be checked if there are:
  - A high number of patients reported on the “unknown” line
  - Invalid ZIP codes with more than 10 patients reported
  - Potential totaling errors across the ZIP Code Table and Table 3A, 3B, and 4

Table 3A Data Checks

- Table 3A data should be checked if there are:
  - Totaling errors across the ZIP Code Table, and Tables 3A, 3B, and 4
  - Inconsistencies between identified universe counts for clinical measures by age and/or gender
  - Age ranges or genders that you appear to no longer report
  - Grant Report values that exceed the Universal Report for the corresponding cell *(applicable to those with multiple funding streams*)
  - Ages not based on June 30 of the reporting year

Table 3B Data Checks

- Table 3B data should be checked if there are:
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4
  - A high number of unreported race or ethnicity
  - Inconsistencies between data sources and reporting across Tables 3B and 7
  - No patients reported who are best served in a language other than English, but patients with linguistic barriers are served
  - Grant Report values that exceed the Universal Report for the corresponding cell *(applicable to those with multiple funding streams*)

Table 4 Data Checks

- Table 4 data should be checked if there are:
  - Totaling errors across the ZIP Code Table and Tables 3A, 3B, and 4
  - A high number of patients with unknown income
  - A high number of uninsured patients, especially given transitions to insurance
  - Large numbers of adults reported as being insured by CHIP
  - Public employees insurance, state or local safety net programs, and/or grant-supported clinical care programs (e.g., BCCCP, Title X) in place and patients are reported as having other public insurance

Table 4 Data Checks, continued

- Table 4 data should be checked if there are:
  - Enrollees reported for behavioral health or dental only managed care plans or missing enrollment data
  - PCCM programs or CMS PCMH Demonstration grants reported as managed care
  - Mismatches between insurance and managed care and revenue
  - No special populations served
  - Grant Report values that exceed the Universal Report for the corresponding cell *(applicable to those with multiple grants*)

Table 5 Data Checks

- Table 5 data should be checked if there are:
  - More total patients on Table 3A than total patients reported on Table 5
  - Multiple types of services provided (e.g., medical, dental, mental health) but total patients on Table 5 equals total patients on Table 3A
  - Staffing FTE or service category reported but no costs on Table 8A or vice versa
  - Head counts reported, rather than FTE
  - Visits per patient averages that are unusually high or low
  - Grant Report values that exceed the Universal Report for the corresponding cell *(applicable to those with multiple streams)*

Table 5A Data Checks

- Table 5A data should be checked if there are:
  - Unusually high average tenure by provider type
  - Average tenure less than twelve months for long-standing organizations and/or providers
  - Head counts equal to FTE

Table 6A Data Checks

- Table 6A data should be checked if there are:
  - Average visits per patient that are unusually high or low
  - Mismatches in services reported on Table 6A as compared to Table 5 (e.g., dental on Table 5 but no dental services on 6A)
  - Significant differences in universe counts (hypertension, diabetes) reported on Table 7 as compared to Table 6A patients seen with diagnosis
  - Potential duplications due to ICD-9 to ICD-10 conversion
  - Apparent reporting of primary diagnosis only
  - Grant Report values that exceed the Universal Report for the corresponding cell *(applicable to those with multiple grants)*

Table 6B Data Checks

- Table 6B data should be checked if there are:
  - Prenatal patients who started the prior year missing from prenatal count
  - No prenatal care patients reported
  - No prenatal care patients reported as having initiated care with another provider (but some have transferred into your care)
  - Large under- or over-counts in the universe/prevalence as compared to patients in age range who received medical care (or dental care for dental measure)
  - 0% or 100% compliance
  - Patients missing from Column B (EHR or sample) who are relevant to the measure (e.g., immunization measure is missing pediatric patients seen by one clinic that sees a large number of infants)
  - Sampling of charts being used—ensure employing a random sample

Table 7 Data Checks

- Table 7 data should be checked if there are:
  - High or low proportion of deliveries as compared to prenatal care patient count
  - No indication of multiple births reflected in larger prenatal programs
  - Inconsistencies between race and ethnicity data reported on Table 7 as compared to Table 3B, resulting in high or low outcome or prevalence data
  - Large under- or over-counts in the universe/prevalence as compared to patients in age range who received medical care
  - 0% or 100% compliance
  - Patients missing from Column B (EHR or sample) who are relevant to the measure (e.g., new site specializing in chronic diseases—hypertension and diabetes—not yet integrated with current EHR)

Table 8A Data Checks

- Table 8A data should be checked if there are:
  - Costs reported but no staffing FTE or service category reported on Table 5 or vice versa
  - Very high or low costs per FTE
  - Inconsistent or missing overhead allocation methods
  - Very high or very low allocations of non-clinical support and/or facility costs as a percent of total costs
  - Unexplainably high or low costs per patient or costs per visit
  - Significant surplus or deficit, possibly due to reporting methodology errors
  - Donations missing (volunteers, pro bono, vaccines, supplies, services)

Table 9D Data Checks

- Table 9D data should be checked if there are:
  - Mismatches between payer categories (Table 9D) and insurance and/or managed care enrollment (Table 4)
    - Very low or very high PMPM rates
    - Insurance and/or managed care reporting but no or low charges or vice versa
    - Charges as a percent of total are not similar to insurance coverage percent
  - No reclassification of charges to appropriate payer lines
  - Retroactive settlements and receipts not included in collections
  - Capitation lines with balances
  - Multi-year negative accounts receivables (for self-pay)
  - Average charge per patient or visit that are high or low
  - Significant surplus or deficit, possibly due to reporting methodology errors (accrued vs. cash, missing revenue or costs)

Table 9E Data Checks

- Table 9E data should be checked if there are:
  - Pharmaceutical sales to patients, capital received as a loan, or value of donated services reported as other revenue
  - Grant funds that pay for units of service (e.g., BCCCP, FP, TB) reported as state or local grants
  - Private contracts with tribes or state insurance plans reported as indigent care program dollars
  - Revenue reported by originator, not “last party”
  - Significant surplus or deficit, possibly due to reporting methodology errors (accrued vs. cash, missing revenue or costs)

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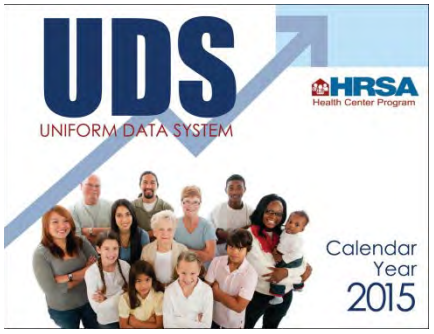
Other Considerations

Multiple Systems

- Extra attention is required to ensure accurate reporting under the following multiple system situations:
  - Transitioning systems (e.g., mid-year)
  - Data from multiple sources
  - Fiscal reporting cycle
  - New sites or new providers or revised scope
  - Data from external contractors
- In these situations, the health center may need to pull data from these multiple systems, consolidate into another system, and un-duplicate patient activity
  - Allow for sufficient time to complete this process

EHR Considerations

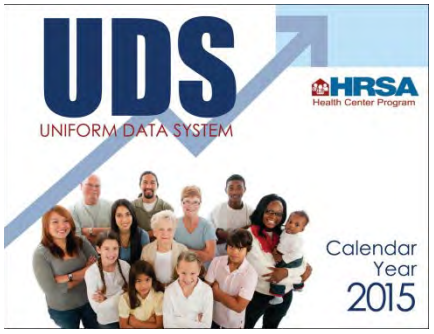


- Programming EHR
  - Ensure EHR has latest specifications in place
- Working with your vendor
  - Most vendors have UDS packages with varying ranges of support services (e.g., documentation to pull data, webinars, forums, direct consulting)
  - Work closely with your vendor to ensure you understand where data is being extracted to create your report
  - Know who to contact if you have questions or concerns
- Testing accuracy and assessing ability to use EHR for performance measurement
  - Understand what UDS reporting capabilities your EHR provides and consider if it requires any configurations
    - Refined systems should be tested to ensure validity of data and optimize workflow

Training on UDS

- Staff involved in UDS reporting need to understand how to support the submission and review process
- Train/orient staff on EHR and UDS reporting
- Develop clear documented processes for staff
- Ensure that staff attend in-person trainings, listen to modules, and participate in webinars to understand UDS content and provide forum for addressing questions
- Read the UDS Reporting Instructions
- Contact UDS Support Line for content questions throughout the year: 866-UDS HELP or udshelp330@bphcdata.net

Critical Dates in UDS Process



2015

UDS TRAININGS START 10/27/2015

EHB OPENS 1/1/2016

UDS REPORT DUE 2/15/2016

REVIEW PERIOD 3/31/2016

REPORT FEEDBACK Summer 2016

Oct.-Dec. 2015 | **Jan. 2016** | **Feb. 2016** | **Mar. 2016** | **Jun.-Aug. 2016**

2016

OCT. 2015- JAN. 2016
CONTENT TRAININGS: In-person trainings, modules, and webinars are available prior to submission

JAN. 1 – FEB. 15, 2016
DATA ENTRY: Report through EHB ("Electronic Handbooks") beginning 1/1/2016

FEB. 15 – MAR. 31, 2016
REPORT AND REVIEW PROCESS: Work with UDS reviewer to address data issues and finalize data submission

JUNE – AUGUST 2016
REPORT FEEDBACK: Rollups, trend, and comparison reports available

Training Opportunities can be found at: Health Center Data and Reporting and BPHC Training Website
UDS Support at: 866-837-4357 or udshelp330@bphcdata.net

HRSA Electronic Handbook:
https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx

EHB Resources: EHB training available through HELP in application and online training module

EHB incorporates hundreds of edits to alert you to possible problems that require follow-up

EHB assistance is available through:

- HRSA Call Center for EHB account access and roles: 877-464-4772 or HRSA Electronic Handbooks Contact Center
- BPHC Help Desk for EHB system issues: 301-443-7356

Strategies for Successful Reporting

- Work as a team
  - Tables are inter-related
- Adhere to definitions and instructions
  - Refer to manual, fact sheets, and other resources and apply definitions
- Check your data before submitting
  - Check data trends and relationships across tables, review last year's reviewer's letter, and compare data to benchmarks
  - Address edits in EHB by correcting or providing explanations that demonstrate your understanding
    - "Number is correct" is not sufficient
  - Report on time, but do not submit incomplete reports
- Work with your reviewer

Questions?


UDS
UNIFORM DATA SYSTEM
HRSA
Health Center Program
Calendar
Year
2015

Thank You

Thank you for attending this webinar
and for all of your efforts to provide comprehensive and accurate data on the Health Center Program.

Ongoing questions can be addressed to
UDSHelp330@BPHCDATA.NET

or

866-UDS-HELP